EXHIBIT E

Progress Notes

Arthur G Yin at 08/05/21 1039

Author: Arthur G Yin | Service: — | Author Type: Physician
Filed: 08/05/21 1039 | Encounter Date: 8/5/2021 | Status: Addendum
Editor: Arthur G Yin (Physician)
Related Notes: Original Note by Arthur G Yin (Physician) filed at 08/05/21 1002

Procedure Orders
1. Ear Cerumen Removal [355393144] ordered by Yin, Arthur G, MD
Post-procedure Diagnoses
1. Bilateral impacted cerumen [H61.23]

Subjective

Markcus Kitchens is a 29 y.o. male.

Chief Complaint
Patient presents with
- Follow-up
- ADD
- Anxiety

History of Present Illness
Patient here for follow-up. Anxiety especially test anxiety much improved after propranolol. ADD stable on medication needs medicine refill. No palpitation headache blood pressure problem no chest pain no short of breath. Patient also complains of earwax both sides.

Current Outpatient Medications:
- amphetamine-dextroamphetamine (ADDERALL) 15 MG tablet, Take 1 tablet by mouth 2 (Two) Times a Day., Disp: 60 tablet, Rfl: 0
- propranolol (INDERAL) 20 MG tablet, Take 1 tablet by mouth 3 (Three) Times a Day., Disp: 270 tablet, Rfl: 3

The following portions of the patient's history were reviewed and updated as appropriate: allergies, current medications, past family history, past medical history, past social history, past surgical history and problem list.

Review of Systems
Constitutional: Negative.
Respiratory: Negative.
Cardiovascular: Negative.
Gastrointestinal: Negative.
Musculoskeletal: Negative.
Skin: Negative.
Neurological: Negative.
Psychiatric/Behavioral: Negative.

Objective

Physical Exam
Constitutional:
Appearance: He is well-developed.
HENT:
Ears:
Comments: **Cerumen impaction bilaterally**
Cardiovascular:
Rate and Rhythm: Normal rate and regular rhythm.
Heart sounds: Normal heart sounds.
Pulmonary:
Effort: Pulmonary effort is normal.
Breath sounds: Normal breath sounds.
Abdominal:
General: Bowel sounds are normal.
Palpations: Abdomen is soft.

Musculoskeletal:
Cervical back: Neck supple.
Neurological:
Mental Status: He is alert and oriented to person, place, and time.
Psychiatric:
Behavior: Behavior normal.

All tests have been reviewed.

Assessment/Plan

Diagnoses and all orders for this visit:

Bilateral impacted cerumen

Attention deficit disorder, unspecified hyperactivity presence
- amphetamine-dextroamphetamine (ADDERALL) 15 MG tablet; Take 1 tablet by mouth 2 (Two) Times a Day.

Test anxiety
- propranolol (INDERAL) 20 MG tablet; Take 1 tablet by mouth 3 (Three) Times a Day.

Ear Cerumen Removal

Date/Time: **8/5/2021 10:38 AM**
Performed by: **Yin, Arthur G, MD**
Authorized by: **Yin, Arthur G, MD**
Consent: **Verbal consent obtained**. **Written consent not obtained**.
Risks and benefits: **risks, benefits and alternatives were discussed**
Consent given by: **patient**
Patient understanding: **patient states understanding of the procedure being performed**

Anesthesia:
Local Anesthetic: **none**
Location details: **right ear and left ear**
Comments: **No complication**
Procedure type: **irrigation**
Sedation:
Patient sedated: **no**

3 months follow-up

Progress Notes

Tina Holbrook at 11/14/22 0910

Author: Tina Holbrook | Service: — | Author Type: Nurse Practitioner
Filed: 11/14/22 0910 | Encounter Date: 11/14/2022 | Status: Signed
Editor: Tina Holbrook (Nurse Practitioner)

This provider is located at The Baptist Health Medical Group, Behavioral Health ,Suite 23, 789 Eastern Bypass in Richmond, Kentucky 40475, using a secure MyChart Video Visit through *EPIC.* Patient is being seen remotely via telehealth at their home address in Kentucky 40475, and stated they are in a secure environment for this session. The patient's condition being diagnosed/treated is appropriate for telemedicine. The provider identified herself as well as her credentials. The patient, and/or patients guardian, consent to be seen remotely, and when consent is given they understand that the consent allows for patient identifiable information to be sent to a third party as needed. They may refuse to be seen remotely at any time. The electronic data is encrypted and password protected, and the patient and/or guardian has been advised of the potential risks to privacy not withstanding such measures.

You have chosen to receive care through a telehealth visit. Do you consent to use a video/audio connection for your medical care today? Yes

Subjective

Markcus Kitchens is a 30 y.o. male who presents today for follow up

Chief Complaint: Anxiety, depression and ADHD

History of Present Illness:
History of Present Illness
Markcus Kitchens presents today via MyChart video visit for medication management follow-up. Reports that he has been doing well overall with managing symptoms associated with both anxiety and depression. Admits that he has not been as consistent with taking fluoxetine as he had in the past. Feels that much of his symptoms are due to situational stressors. Reports Adderall has done well controlling ADHD symptoms. Says that he has days that he does not take medication if he does not have any scheduled tasks that require sustained mental effort. Sleeping about 7 hours each night. He does report taking OTC melatonin to help with sleep. Appetite is good. Denies any SI/HI or A/V hallucinations.

The following portions of the patient's history were reviewed and updated as appropriate: allergies, current medications, past family history, past medical history, past social history, past surgical history and problem list.

Past Medical History:
History reviewed. No pertinent past medical history.

Social History:
Social History

Socioeconomic History	
• Marital status:	Married
Tobacco Use	
• Smoking status:	Never
• Smokeless tobacco:	Never
Substance and Sexual Activity	
• Alcohol use:	Never
• Drug use:	Never
• Sexual activity:	Yes
Partners:	Female

Family History:
History reviewed. No pertinent family history.

Past Surgical History:
Past Surgical History:

Procedure	Laterality	Date
• WISDOM TOOTH EXTRACTION	N/A	

Problem List:
Patient Active Problem List
Diagnosis
- Anxiety
- Attention deficit disorder

Allergy:
No Known Allergies

Current Medications:
Current Outpatient Medications

Medication	Sig	Dispense	Refill
• amphetamine-dextroamphetamine (ADDERALL) 20 MG tablet	TAKE 1 TABLET BY MOUTH TWO TIMES A DAY FOR 30 DAYS	60 tablet	0
• FLUoxetine (PROzac) 10 MG capsule	Take 1 capsule by mouth Daily for 60 days.	30 capsule	1
• propranolol (INDERAL) 20 MG tablet	Take 1 tablet by mouth 3 (Three) Times a Day.	270 tablet	3

No current facility-administered medications for this visit.

Review of Symptoms:
Review of Systems
Constitutional: Negative for activity change, appetite change, fatigue, unexpected weight gain and unexpected weight loss.
Respiratory: Negative for shortness of breath.
Cardiovascular: Negative for chest pain.
Psychiatric/Behavioral: Positive for decreased concentration and depressed mood. Negative for sleep disturbance. The patient is nervous/anxious.

Physical Exam:
Physical Exam
Constitutional:
General: He is not in acute distress.
Appearance: Normal appearance.
Neurological:
Mental Status: He is alert.
Vitals:
There were no vitals taken for this visit. There is no height or weight on file to calculate BMI.
Due to extenuating circumstances and possible current health risks associated with the patient being present in a clinical setting (with current health restrictions in place in regards to possible COVID 19 transmission/exposure), the patient was seen remotely today via a MyChart Video Visit through EPIC. Unable to obtain vital signs due to nature of remote visit.

Mental Status Exam:
Hygiene: appears good
Cooperation: Cooperative
Eye Contact: UTA
Psychomotor Behavior: Appropriate
Affect: Appropriate
Mood: normal
Hopelessness: Denies
Speech: Normal
Thought Process: Goal directed and Linear
Thought Content: Mood congruent
Suicidal: None
Homicidal: None
Hallucinations: None
Delusion: None
Memory: Intact
Orientation: Person, Place, Time and Situation
Reliability: good
Insight: Fair
Judgement: Good
Impulse Control: Good

Lab Results:
Office Visit on 08/25/2022

Component	Date	Value	Ref Range	Status
• Report Summary	08/25/2022	FINAL		Final

Comment:

```
========================================================================
TOXASSURE COMP DRUG ANALYSIS,UR
========================================================================
Test                      Result       Flag       Units
Drug Absent but Declared for Prescription Verification
  Amphetamine                 Not Detected UNEXPECTED ng/mg creat
  Propranolol                 Not Detected UNEXPECTED
========================================================================
Test                 Result    Flag   Units      Ref Range
  Creatinine           25              mg/dL      >=20
========================================================================
Declared Medications:
 The flagging and interpretation on this report are based on the
 following declared medications.  Unexpected results may arise from
 inaccuracies in the declared medications.
 **Note: The testing scope of this panel includes these medications:
 Amphetamine (Amphetamine-Dextroamphetamin
              e)
 Propranolol
========================================================================
For clinical consultation, please call (866) 593-0157.
========================================================================
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EKG Results:
No orders to display

Assessment & Plan

Problems Addressed this Visit

Mental Health
Attention deficit disorder - Primary

Other Visit Diagnoses
Generalized anxiety disorder
Moderate episode of recurrent major depressive disorder (HCC)

Diagnoses

	Codes	Comments
Attention deficit disorder, unspecified hyperactivity presence - Primary	ICD-10-CM: F98.8 ICD-9-CM: 314.00	
Generalized anxiety disorder	ICD-10-CM: F41.1 ICD-9-CM: 300.02	
Moderate episode of recurrent major depressive disorder (HCC)	ICD-10-CM: F33.1 ICD-9-CM: 296.32	

Visit Diagnoses:

		ICD-10-CM	ICD-9-CM
1.	**Attention deficit disorder, unspecified hyperactivity presence**	**F98.8**	**314.00**
2.	Generalized anxiety disorder	F41.1	300.02
3.	Moderate episode of recurrent major depressive disorder (HCC)	F33.1	296.32

-Reviewed previous available documentation and most recent available labs. KASPER reviewed and is appropriate. UDS on file from 8/25/22 is appropriate. Signed controlled substance agreement on file. Patient counseled on use of controlled substances.

-Discussed importance of counseling to decrease anxiety like symptoms. Discussed coping mechanisms to decrease stress and anxiety: relaxation techniques, guided imagery, music therapy, staying active, support groups, diversional activities and avoid aggravating factors.
Discussed different coping mechanisms to better control depression.

-The benefits of a healthy diet and exercise were discussed with patient, especially the positive effects they have on mental health. Patient encouraged to consider lifestyle modification regarding diet and exercise patterns to maximize results of mental health treatment.

Encouraged patient to practice good sleep hygiene. Discussed going to bed at the same time and getting

up at the same time every day. Consider a quiet activity, such as reading, part of your nighttime routine. Make your bedroom a dark, comfortable place where it is easy to fall asleep. Avoid or limit caffeine consumption. Limit screen use, especially two hours prior to bed (this includes watching TV, using smartphone, tablet or computer).

Discussed plan of care and medication regimen. We will continue Adderall as previously prescribed as he reports adequate control of symptoms associated with ADHD. Denies any adverse effects of medication. Admits that he has not been consistent with taking fluoxetine. Feels that he has been able to manage symptoms associated with anxiety and depression using learned coping skills. He does report feeling more emotional on occasion and with season change, maybe he should be more consistent with taking medication. Also says that his situation involving the medical board has sometimes caused exacerbation in symptoms. Denies any adverse effects of medication.
-Continue fluoxetine 10 mg daily for anxiety and depression
-Continue Adderall 20 mg twice daily for ADHD symptoms (no refill needed at this time)
-Continue Propranolol 20 mg three times daily for anxiety as previously prescribed.

GOALS:
Short Term Goals: Patient will be compliant with medication, and patient will have no significant medication related side effects. Patient will be engaged in psychotherapy as indicated. Patient will report subjective improvement of symptoms.
Long term goals: To stabilize mood and treat/improve subjective symptoms, the patient will stay out of the hospital, the patient will be at an optimal level of functioning, and the patient will take all medications as prescribed.
The patient/guardian verbalized understanding and agreement with goals that were mutually set.

TREATMENT PLAN: Continue supportive psychotherapy efforts and medications as indicated for patient's diagnosis. Pharmacological and Non-Pharmacological treatment options discussed during today's visit. Patient/Guardian acknowledged and verbally consented with current treatment plan and was educated on the importance of compliance with treatment and follow-up appointments.

MEDICATION ISSUES:
Discussed medication options and treatment plan of prescribed medication as well as the risks, benefits, any black box warnings, and side effects including potential falls, possible impaired driving, and metabolic adversities among others. Patient is agreeable to call the office with any worsening of symptoms or onset of side effects, or if any concerns or questions arise. The contact information for the office is made available to the patient. Patient is agreeable to call 911 or go to the nearest ER should they begin having any SI/HI, or if any urgent concerns arise. No medication side effects or related complaints today.

MEDS ORDERED DURING VISIT:
No orders of the defined types were placed in this encounter.

FOLLOW UP:
Return in about 8 weeks (around 1/9/2023) for Recheck.

I spent 30 minutes caring for Markcus on this date of service. This time includes time spent by me in the following activities: preparing for the visit, obtaining and/or reviewing a separately obtained history, performing a medically appropriate examination and/or evaluation, counseling and educating the patient/family/caregiver, ordering medications, tests, or procedures and documenting information in the medical record.

This document has been electronically signed by *Tina Holbrook, APRN*
November 14, 2022 09:07 EST

Please note that portions of this note were completed with a voice recognition program. Efforts were made to edit dictation, but occasionally words are mistranscribed.

Progress Notes

Tina Holbrook at 01/10/23 1034

Author: Tina Holbrook | Service: — | Author Type: Nurse Practitioner
Filed: 01/10/23 1034 | Encounter Date: 1/10/2023 | Status: Signed
Editor: Tina Holbrook (Nurse Practitioner)

This provider is located at The Baptist Health Medical Group, Behavioral Health ,Suite 23, 789 Eastern Bypass in Richmond, Kentucky 40475, using a secure MyChart Video Visit through *EPIC.* Patient is being seen remotely via telehealth at their home address in Kentucky 40475, and stated they are in a secure environment for this session. The patient's condition being diagnosed/treated is appropriate for telemedicine. The provider identified herself as well as her credentials. The patient, and/or patients guardian, consent to be seen remotely, and when consent is given they understand that the consent allows for patient identifiable information to be sent to a third party as needed. They may refuse to be seen remotely at any time. The electronic data is encrypted and password protected, and the patient and/or guardian has been advised of the potential risks to privacy not withstanding such measures.

You have chosen to receive care through a telehealth visit. Do you consent to use a video/audio connection for your medical care today? Yes

Subjective

Markcus Kitchens is a 30 y.o. male who presents today for follow up

Chief Complaint: Anxiety, depression and ADHD

History of Present Illness:
History of Present Illness
Markcus Kitchens presents today via MyChart video visit for medication management follow-up. Reports that he is doing well overall, says that he is currently getting over a sinus infection. Verbalizes that he recently went on a 5-day cruise with his family and feels that this was a good experience and stress relief for him. He continues to be in the lawsuit with the medical testing board. Has missed residency deadlines so component has been postponed. Says that he has been more accepting and positive about current situation. Has been interviewing for different positions that require MD without the clinical component. Says that he and his wife have considered transitioning to Atlanta, where his uncle owns a law firm and his wife could work at this firm. Reports that he stopped taking Prozac about 2 weeks after last visit (November) and feels that he has been managing overall symptoms of depression and anxiety well on his own. Feels that overall ADHD symptoms are controlled with current regimen. Says that he does not take Adderall every day as he does not feel he needs to take medication when sustained mental effort is not required. Sleeping about an average of 7 hours per night. Reports appetite is good. Denies any adverse effects of current medication regimen. Denies any SI/HI or A/V hallucinations.

The following portions of the patient's history were reviewed and updated as appropriate: allergies, current medications, past family history, past medical history, past social history, past surgical history and problem list.

Past Medical History:
History reviewed. No pertinent past medical history.

Social History:
Social History

Socioeconomic History
- Marital status: Married

Tobacco Use
- Smoking status: Never
- Smokeless tobacco: Never

Substance and Sexual Activity
- Alcohol use: Never
- Drug use: Never
- Sexual activity: Yes
  Partners: Female

Family History:
History reviewed. No pertinent family history.

Past Surgical History:
Past Surgical History:

Procedure	Laterality	Date
• WISDOM TOOTH EXTRACTION	N/A	

Problem List:
Patient Active Problem List
Diagnosis
- Anxiety
- Attention deficit disorder

Allergy:
No Known Allergies

Current Medications:
Current Outpatient Medications

Medication	Sig	Dispense	Refill
• amphetamine-dextroamphetamine (ADDERALL) 20 MG tablet	Take 1 tablet by mouth 2 (Two) Times a Day.	60 tablet	0
• propranolol (INDERAL) 20 MG tablet	Take 1 tablet by mouth 3 (Three) Times a Day.	270 tablet	3

No current facility-administered medications for this visit.

Review of Symptoms:
Review of Systems
Constitutional: Negative for activity change, appetite change, fatigue, unexpected weight gain and unexpected weight loss.
Respiratory: Negative for shortness of breath.
Cardiovascular: Negative for chest pain.
Psychiatric/Behavioral: Positive for decreased concentration and depressed mood. Negative for sleep disturbance. The patient is nervous/anxious.

Physical Exam:
Physical Exam
Constitutional:
General: He is not in acute distress.
Appearance: Normal appearance.
Neurological:
Mental Status: He is alert.
Vitals:
There were no vitals taken for this visit. There is no height or weight on file to calculate BMI.
Due to extenuating circumstances and possible current health risks associated with the patient being present in a clinical setting (with current health restrictions in place in regards to possible COVID 19 transmission/exposure), the patient was seen remotely today via a MyChart Video Visit through EPIC. Unable to obtain vital signs due to nature of remote visit.

Mental Status Exam:
Hygiene: appears good
Cooperation: Cooperative
Eye Contact: UTA
Psychomotor Behavior: Appropriate
Affect: Appropriate
Mood: normal
Hopelessness: Denies
Speech: Normal
Thought Process: Goal directed and Linear
Thought Content: Mood congruent
Suicidal: None
Homicidal: None
Hallucinations: None
Delusion: None
Memory: Intact
Orientation: Person, Place, Time and Situation
Reliability: good
Insight: Fair
Judgement: Good
Impulse Control: Good

Lab Results:
Office Visit on 08/25/2022

Component	Date	Value	Ref Range	Status
• Report Summary	08/25/2022	FINAL		Final

Comment:

```
==========================================================================
TOXASSURE COMP DRUG ANALYSIS,UR
==========================================================================
Test                  Result      Flag      Units
Drug Absent but Declared for Prescription Verification
  Amphetamine                 Not Detected UNEXPECTED ng/mg creat
  Propranolol                 Not Detected UNEXPECTED
==========================================================================
Test                Result    Flag   Units      Ref Range
  Creatinine          25              mg/dL      >=20
==========================================================================
Declared Medications:
 The flagging and interpretation on this report are based on the
 following declared medications.  Unexpected results may arise from
 inaccuracies in the declared medications.
 **Note: The testing scope of this panel includes these medications:
 Amphetamine (Amphetamine-Dextroamphetamin
              e)
 Propranolol
==========================================================================
For clinical consultation, please call (866) 593-0157.
==========================================================================
```

EKG Results:
No orders to display

Assessment & Plan

Problems Addressed this Visit

Mental Health
Attention deficit disorder
Relevant Medications
amphetamine-dextroamphetamine (ADDERALL) 20 MG tablet

Diagnoses

	Codes	Comments
Attention deficit disorder, unspecified hyperactivity presence	ICD-10-CM: F98.8 ICD-9-CM: 314.00	

Visit Diagnoses:

		ICD-10-CM	ICD-9-CM
1.	Attention deficit disorder, unspecified hyperactivity presence	F98.8	314.00

-Reviewed previous available documentation and most recent available labs. KASPER reviewed and is appropriate. UDS on file from 8/25/22 is appropriate. Signed controlled substance agreement on file. Patient counseled on use of controlled substances.

-Discussed importance of counseling to decrease anxiety like symptoms. Discussed coping mechanisms to decrease stress and anxiety: relaxation techniques, guided imagery, music therapy, staying active, support groups, diversional activities and avoid aggravating factors.
Discussed different coping mechanisms to better control depression.

-The benefits of a healthy diet and exercise were discussed with patient, especially the positive effects they have on mental health. Patient encouraged to consider lifestyle modification regarding diet and exercise patterns to maximize results of mental health treatment.

Encouraged patient to practice good sleep hygiene. Discussed going to bed at the same time and getting up at the same time every day. Consider a quiet activity, such as reading, part of your nighttime routine. Make your bedroom a dark, comfortable place where it is easy to fall asleep. Avoid or limit caffeine consumption. Limit screen use, especially two hours prior to bed (this includes watching TV, using smartphone, tablet or computer).

Discussed medication regimen and plan of care. He is agreeable to continue with Adderall at current dose

as he feels medication is beneficial in controlling ADHD symptoms. Has stopped taking Prozac as he feels that he is able to use coping skills/techniques to manage symptoms associated with anxiety and depression. Says that the symptoms have been more situational and now that he has come to terms with current situation he is better able to manage the symptoms. Continues to take propranolol that has been helpful with anxiety as well. Denies any adverse effects of current medication regimen. Denies any SI/HI.

-Refill Adderall 20 mg twice daily for ADHD symptoms
-Continue Propranolol 20 mg three times daily for anxiety as previously prescribed.

GOALS:
Short Term Goals: Patient will be compliant with medication, and patient will have no significant medication related side effects. Patient will be engaged in psychotherapy as indicated. Patient will report subjective improvement of symptoms.
Long term goals: To stabilize mood and treat/improve subjective symptoms, the patient will stay out of the hospital, the patient will be at an optimal level of functioning, and the patient will take all medications as prescribed.
The patient/guardian verbalized understanding and agreement with goals that were mutually set.

TREATMENT PLAN: Continue supportive psychotherapy efforts and medications as indicated for patient's diagnosis. Pharmacological and Non-Pharmacological treatment options discussed during today's visit. Patient/Guardian acknowledged and verbally consented with current treatment plan and was educated on the importance of compliance with treatment and follow-up appointments.

MEDICATION ISSUES:
Discussed medication options and treatment plan of prescribed medication as well as the risks, benefits, any black box warnings, and side effects including potential falls, possible impaired driving, and metabolic adversities among others. Patient is agreeable to call the office with any worsening of symptoms or onset of side effects, or if any concerns or questions arise. The contact information for the office is made available to the patient. Patient is agreeable to call 911 or go to the nearest ER should they begin having any SI/HI, or if any urgent concerns arise. No medication side effects or related complaints today.

MEDS ORDERED DURING VISIT:
New Medications Ordered This Visit
Medications
- amphetamine-dextroamphetamine (ADDERALL) 20 MG tablet
  Sig: Take 1 tablet by mouth 2 (Two) Times a Day.
  Dispense: 60 tablet
  Refill: 0

FOLLOW UP:
Return in about 3 months (around 4/10/2023) for Recheck, Video visit.

I spent 30 minutes caring for Markcus on this date of service. This time includes time spent by me in the following activities: preparing for the visit, obtaining and/or reviewing a separately obtained history, performing a medically appropriate examination and/or evaluation, counseling and educating the patient/family/caregiver, ordering medications, tests, or procedures and documenting information in the medical record.

This document has been electronically signed by *Tina Holbrook, APRN*
January 10, 2023 10:34 EST

Please note that portions of this note were completed with a voice recognition program. Efforts were made to edit dictation, but occasionally words are mistranscribed.

Progress Notes

Tina Holbrook at 02/07/23 1018

Author: Tina Holbrook | Service: — | Author Type: Nurse Practitioner
Filed: 02/07/23 1018 | Encounter Date: 2/6/2023 | Status: Signed
Editor: Tina Holbrook (Nurse Practitioner)

Subjective

Markcus Kitchens is a 31 y.o. male who presents today for follow up

Chief Complaint: Anxiety and depression

History of Present Illness:
History of Present Illness
Markcus Kitchens presents today requesting a letter with current diagnosis as well as accommodations needed in relation to diagnosis. Verbalizes that he has a current lawsuit and needs to file an injunctive relief that is due today. Says that his lawsuit is against the National Board of Medical Examiners as he has history of ADHD that was diagnosed in childhood, but was denied ADA accommodations when testing for medical boards. Verbalizes that this testing procedure has caused issue with starting a residency program. He has been unable to apply or start a residency program due to 3 failed attempts at passing the medical board testing that is required for residency. Denies any past psychological evaluations to determine accommodations needed. He does say that he was evaluated by a psychologist during college, but declined any type of accommodation. Reports added stressor as he needs to have this lawsuit reviewed by judge that will enable him to obtain the accommodations he needs for testing. Says that he has until May 31 to get both of the tests completed in order to start residency. Says that he needs to wait until the judge's decision before scheduling these tests. Does admit to increased anxiety and depressed mood at times due to current situation, but feels as though he is handling the situation well. Continues to feel that ADHD symptoms are adequately controlled with current medication regimen. PHQ-9 total score: 11, GAD-7 total score: 18.

The following portions of the patient's history were reviewed and updated as appropriate: allergies, current medications, past family history, past medical history, past social history, past surgical history and problem list.

Past Medical History:
History reviewed. No pertinent past medical history.

Social History:
Social History

Socioeconomic History
- Marital status: Married

Tobacco Use
- Smoking status: Never
- Smokeless tobacco: Never

Vaping Use
- Vaping Use: Never used

Substance and Sexual Activity
- Alcohol use: Never
- Drug use: Never
- Sexual activity: Yes
  Partners: Female

Family History:
History reviewed. No pertinent family history.

Past Surgical History:
Past Surgical History:

Procedure	Laterality	Date
• WISDOM TOOTH EXTRACTION	N/A	

Problem List:
Patient Active Problem List
Diagnosis
- Anxiety

- Anxiety
- Attention deficit disorder

Allergy:
No Known Allergies

Current Medications:
Current Outpatient Medications

Medication	Sig	Dispense	Refill
• amphetamine-dextroamphetamine (ADDERALL) 20 MG tablet	Take 1 tablet by mouth 2 (Two) Times a Day.	60 tablet	0
• meloxicam (MOBIC) 7.5 MG tablet	Take 1 tablet by mouth Daily.		
• multivitamin with minerals tablet tablet	Take 1 tablet by mouth Daily.		
• propranolol (INDERAL) 20 MG tablet	Take 1 tablet by mouth 3 (Three) Times a Day.	270 tablet	3

No current facility-administered medications for this visit.

Review of Symptoms:
Review of Systems
Constitutional: Positive for activity change. Negative for appetite change, fatigue, unexpected weight gain and unexpected weight loss.
Respiratory: Negative for shortness of breath.
Cardiovascular: Negative for chest pain.
Psychiatric/Behavioral: Positive for decreased concentration, sleep disturbance, depressed mood and stress. Negative for suicidal ideas. The patient is not nervous/anxious.

Physical Exam:
Physical Exam
Vitals reviewed.
Constitutional:
General: He is not in acute distress.
Appearance: Normal appearance.
Neurological:
Mental Status: He is alert.
Gait: Gait normal.
Vitals:
Blood pressure 104/68, pulse 59, height 180.3 cm (71"), weight 64.9 kg (143 lb).

Mental Status Exam:
Hygiene: good
Cooperation: Cooperative
Eye Contact: Good
Psychomotor Behavior: Appropriate
Affect: Appropriate
Mood: sad, depressed and anxious
Hopelessness: Denies
Speech: Normal
Thought Process: Goal directed and Linear
Thought Content: Mood congruent
Suicidal: None
Homicidal: None
Hallucinations: None
Delusion: None
Memory: Intact
Orientation: Person, Place, Time and Situation
Reliability: good
Insight: Good
Judgement: Good
Impulse Control: Good

Lab Results:
Office Visit on 08/25/2022

Component	Date	Value	Ref Range	Status
• Report Summary	08/25/2022	FINAL		Final

Comment:
==========
TOXASSURE COMP DRUG ANALYSIS,UR
==========

Test	*Result*	*Flag*	*Units*

Drug Absent but Declared for Prescription Verification
Amphetamine Not Detected UNEXPECTED ng/mg creat
Propranolol Not Detected UNEXPECTED

Test	*Result*	*Flag*	*Units*	*Ref Range*
Creatinine	*25*		*mg/dL*	*>=20*

Declared Medications:
The flagging and interpretation on this report are based on the following declared medications. Unexpected results may arise from inaccuracies in the declared medications.
***Note: The testing scope of this panel includes these medications:*
Amphetamine (Amphetamine-Dextroamphetamine)
Propranolol

For clinical consultation, please call (866) 593-0157.

EKG Results:
No orders to display

Assessment & Plan

Problems Addressed this Visit

None

Visit Diagnoses

ADHD (attention deficit hyperactivity disorder), inattentive type - Primary

Diagnoses

	Codes	Comments
ADHD (attention deficit hyperactivity disorder), inattentive type - Primary	ICD-10-CM: F90.0 ICD-9-CM: 314.00	

Visit Diagnoses:

	ICD-10-CM	ICD-9-CM
1. ADHD (attention deficit hyperactivity disorder), inattentive type	**F90.0**	**314.00**

-CPT completed on 2/3/2023, he has a total of 9 atypical T-scores which is associated with a very high likelihood of having a disorder characterized by attention deficits, such as ADHD. His profile of scores and response pattern indicates that he may have issues related to inattentiveness (strong indication), sustained attention (some indication) and vigilance (some indication).

Discussed plan of care and later needed to present for lawsuit. Discussed that a letter with current diagnosis can be provided, but any other details will need to be discussed with collaborating physician. He did obtain an office CPT, copy provided as this is a tool that he can present verifying ADHD diagnosis. Encouraged him to make an appointment for psychological testing as this evaluation is more detailed and will recommend accommodations that may be needed. This evaluation will also rule out other psychological and/or neurological conditions that could potentially cause symptoms of impaired attention, leading to atypical scores on the Conners CPT 3. Reports that current medication regimen works well to control ADHD symptoms. Will continue with current medication regimen as previously prescribed.

-Continue Adderall 20 mg twice daily for ADHD symptoms
-Continue Propranolol 20 mg three times daily for anxiety as previously prescribed by Dr. Yin.

GOALS:
Short Term Goals: Patient will be compliant with medication, and patient will have no significant medication related side effects. Patient will be engaged in psychotherapy as indicated. Patient will report subjective improvement of symptoms.
Long term goals: To stabilize mood and treat/improve subjective symptoms, the patient will stay out of the hospital, the patient will be at an optimal level of functioning, and the patient will take all medications as prescribed.
The patient/guardian verbalized understanding and agreement with goals that were mutually set.

TREATMENT PLAN: Continue supportive psychotherapy efforts and medications as indicated for patient's diagnosis. Pharmacological and Non-Pharmacological treatment options discussed during today's visit. Patient/Guardian acknowledged and verbally consented with current treatment plan and was educated on

the importance of compliance with treatment and follow-up appointments.

MEDICATION ISSUES:
Discussed medication options and treatment plan of prescribed medication as well as the risks, benefits, any black box warnings, and side effects including potential falls, possible impaired driving, and metabolic adversities among others. Patient is agreeable to call the office with any worsening of symptoms or onset of side effects, or if any concerns or questions arise. The contact information for the office is made available to the patient. Patient is agreeable to call 911 or go to the nearest ER should they begin having any SI/HI, or if any urgent concerns arise. No medication side effects or related complaints today.

MEDS ORDERED DURING VISIT:
No orders of the defined types were placed in this encounter.

FOLLOW UP:
Return for Next scheduled follow up in April for medication management.

This document has been electronically signed by *Tina Holbrook, APRN*
February 7, 2023 10:18 EST

Please note that portions of this note were completed with a voice recognition program. Efforts were made to edit dictation, but occasionally words are mistranscribed.